Application Form for
PMB Chronic Disease List Conditions (CDL)
(To comply with the Risk Equalisation Fund (REF) Criteria)
and other chronic conditions

mediscor pbm
Pharmaceutical Benefit Management
Solutions Together

ATTENDING MEDICAL PRACTICIONER TO KINDLY COMPLETE THE RELEVANT SECTIONS AND RETURN ALL PAGES to
PO Box 8796, Centurion, 0046, fax to 0866 151 508 or 0866 151 509 or email to preauth@mediscor.co.za
NB: Please complete one application form per patient.

DATE: ____________________________

Member Information:

Name of Medical Scheme	Principle Member Number as per Card
Principle Member Title and Initials	Principle Member Surname
Principle Member Contact Number (Home)	Principle Member Contact Number (Work)
Principle Member Contact Number (Cell)	Principle Member ID Number
Principle Member E-mail Address	Principle Member Language
Principle Member Address (Postal)	Postal Code

Patient Information:

Dependent Code		Patient/ beneficiary Title and Initials
Patient/ beneficiary Name		Patient/ beneficiary Surname
Patient/ beneficiary Date of Birth	Patient/ beneficiary Gender (M / F)	Patient/ beneficiary ID
Patient/ beneficiary address (if different from member address)		Postal Code
Patient contact number: (Home)	(Work)	(Cell)

Doctor Information:

Dr Initials and Surname		Dr Practice Number
Dr Speciality		E-mail Address
Dr Contact Numbers: (Rooms)	(Fax)	(Cell)

CLINICAL ENTRY CRITERIA FOR THE PMB-CDL CONDITIONS TO BE COMPLETED BY THE TREATING PHYSICIAN:

In order for a patient /beneficiary to qualify for the PMB benefit and to fulfil the requirements of the Risk Equalisation Fund (REF), the medical practitioner must supply the relevant information per disease condition on the following pages.

Authorisations are subject a formulary. The formulary level is determined by the scheme option chosen. The formulary can be viewed at www.mediscor.net

The attending medical practitioner's signature is required on each page to confirm the CDL condition together with the appropriate ICD-10 code.
Failure to complete the application, with the relevant signatures from the patient and the treating physician, as well as providing the required information, will result in non-registration of the condition.

Declaration:

I declare and understand that this application shall be null and void if any information supplied by me and/or my dependants should be false or incomplete. In which case I will repay all monies paid to me and/or my dependants (or on my behalf) by the scheme for benefits received for the treatment of any of the disease conditions ticked.
I give my irrevocable consent to any medical doctor, person or organization that may possess, or come into possession of any medical information to disclose this information to the scheme, to the extent permitted by law.

____

SIGNATURE (Principal Member)

Signed at ______________________________ on this ________ day of ______________________ 20 _____

PATIENT DETAILS:

Medical Scheme	Patient Initials and Surname
Member Number	Patient Dependent Code

CARDIOVASCULAR DIseases:

Disease	√	ICD-10 Code	Clinical Entry Criteria / Remarks
Cardiac Failure			
Cardiomyopathy			
Coronary Artery Disease			
Dysrhythmias			
Hypertension			
Hyperlipidaemia			BP reading: Height: Weight: Exercise: Yes/ No Smoking: Yes / No Date of Lipogram:

Lipogram Reading:

TCL:	LDL:	HDL:	Triglycerides:

Risk Factors: (Please indicate where applicable)

Family History		Hypertension		Angina/Myocardial infarction		Angioplasty/Stent
Cerebrovascular Accident (CVA)		Transient Ischaemic Attack		Peripheral Vascular Disease		

ENDOCRINOLOGY:

Disease	½	ICD-10 Code	Clinical Entry Criteria / Remarks
Addison¢s Disease			
Diabetes Insipidus			
Diabetes Mellitus 1			
Diabetes Mellitus 2			
Hypothyroidism			

RESPIRATORY DISEASES:

Disease	√	ICD-10 Code	Clinical Entry Criteria / Remarks
Asthma			Mild Intermittent [ ] Mild Persistent [ ] Moderate Persistent [ ] Severe Persistent [ ]
Bronchiectasis			
Chronic Obstructive Pulmonary Disease (COPD)			Stage 1 [ ] Stage 2 [ ] Stage 3 [ ] Initial FEV 1 (spirometry report):

AUTO IMMUNE DISEASES:

Disease	√	ICD-10 Code	Clinical Entry Criteria / Remarks
Multiple Sclerosis			*** Please note that confirmation of diagnosis is required from a Neurologist** **Neurologist Practice Number:**
Systemic Lupus Erythematosus			

Prescribing Doctor Signature:	**Date:**
Patient Signature:	

PMB conditions

PATIENT DETAILS:

Medical Scheme	Patient Initials and Surname
Member Number	Patient Dependent Code

AUTO IMMUNE DISEASES: (Continue)

Disease	√	ICD-10 Code	Clinical Entry Criteria / Remarks
Rheumatoid Arthritis			*** Please tick the appropriate initial symptoms:**
			☐ Morning stiffness lasting at least one hour before maximal improvement, for at least 6 consecutive weeks.
			☐ Soft tissue swelling or effusion, observed by a physician, in at least three of the following joint areas (right or left): proximal interphalangeal (PIP), metacarpophalangeal (MCP), wrist, elbow, knee, ankle or metatarsophalangeal (MTP) joints, for at least 6 consecutive weeks.
			☐ Swelling or effusion, observed by a physician, in the proximal interphalangeal, metacarpophalangeal, or wrist joints, for at least 6 consecutive weeks.
			☐ Symmetrical (right and left sides) swelling or fluid in the joints mentioned in point 2, observed by a physician, for at least 6 consecutive weeks.
			☐ Subcutaneous nodules over bony prominences or extensor surfaces, or in juxta articular regions, observed by a physician.
			☐ Demonstration of serum rheumatoid factor (RF) detected by any method that has been positive in less than 5% of control subjects.
			☐ Radiographic evidence in the hands or wrists of articular erosions or osteopenia in or around the affected joints.

INFLAMMATORY BOWEL DISEASES:

Disease	√	ICD-10 Code	Clinical Entry Criteria / Remarks
Crohn's Disease			
Ulcerative Colitis			

CENTRAL NERVOUS SYSTEM DISEASES:

Disease	√	ICD-10 Code	Clinical Entry Criteria / Remarks
Bipolar Mood Disorder			*** Please note that confirmation of diagnosis is required from a Psychiatrist** **Psychiatrist Practice Number:**
Epilepsy			
Parkinson's Disease			
Schizophrenia			*** Please note that confirmation of diagnosis is required from a Psychiatrist** **Psychiatrist Practice Number:**

OTHER DISEASES:

Disease	√	ICD-10 Code	Clinical Entry Criteria / Remarks
Chronic Renal Disease			* Glomerular Filtration rate/Creatinine clearance required
Glaucoma			
Haemophilia			

Prescribing Doctor Signature:	**Date:**
Patient Signature:	

HIV/AIDS:

Please contact your medical scheme to enrol on a disease management programme

ONCOLOGY:

Please contact your medical scheme to enrol on the oncology programme

PMB conditions

OTHER CHRONIC CONDITIONS:

Please note: The following conditions may be reimbursed depending on your medical scheme option.
***** *Additional information may be required*

Disease	½	ICD-10 Code	Clinical Remarks
ADHD (in children)*			*** Please note that confirmation of diagnosis is required from a specialist** **Specialist Practice Number:**
Allergic Rhinitus			
Alzheimerϕs disease*			*** Please note that confirmation of diagnosis is required from a specialist** **Specialist Practice Number:**
Ankolysing spondolytis			
Chronic depression*			* Please supply DSM IV classification
Cushingϕs disease			
Cystic Fibrosis			
Endocarditis prophylacsis			
Endometriosis*			*** Please note that confirmation of diagnosis is required from a specialist** **Specialist Practice Number:**
Gastro oesophageal reflux disease			* Please submit copy of gastroscopy report
Gout			
Isovaleric acidaemia			
Menopause (Hormone replacement therapy)			
Motor neurone disease			
Organ transplant (immunosuppresants)			
Osteo-arthritis			
Osteoporosis*			* Please submit copy of Bone density report (dexa-scan)
Pagetϕs disease			
Prostatic hypertrophy(benign)			
Pseudohypoparathyroidism			
Psoriasis			
Touretteϕs syndrome			
Wilsonϕs disease			

Medicine prescribed: DESCRIPTION	**DOSAGE**	**STRENGTH**

Prescribing Doctor Signature:	**Date:**